U.S. Department of Labor

Office of Administrative Law Judges
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Issue Date: 03 February 2003

CASE NO. 2002-BLA-261

In the Matter of

HERMAN M. WAGNER, Deceased, by FRED WAGNER, Executor,[1] .
Claimant

v.

CONSOLIDATION COAL CO.,
Employer

and

DIRECTOR, OFFICE OF WORKERS' COMPENSATION PROGRAMS,
Party-in-Interest

APPEARANCES:

James Hook, Esquire
For the Claimant

Kathy L. Snyder, Esquire
For the Employer

Before: ROBERT J. LESNICK
Administrative Law Judge

DECISION AND ORDER ON MODIFICATION REQUEST-DENYING BENEFITS

This proceeding arises from claims for benefits under the Black Lung Benefits Act, 30 U.S.C. §901, *et seq.* Regulations implementing the Act were published by the Secretary of Labor and appear at Parts 718 and 725 of Title 20 of the Code of Federal Regulations.[2]

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[1] Since Herman Wagner died during the pendency of his claim, and Fred Wagner is the executor of the estate, the caption has been amended pursuant to Claimant counsel's request (TR 12-13).

[2] The Secretary of Labor adopted amendments to the "Regulations Implementing the Federal Coal Mine Health and Safety Act of 1969" as set forth in Federal Register/Vol. 65, No. 245 Wednesday, December 20, 2000. The revised Part 718 regulations became effective on January 19, 2001 and were to apply to both pending and newly filed cases. The new Part 725 regulations also became effective on January 19, 2001. Some of the new procedural aspects of the Part 725 regulations, however, were to apply only to claims filed on or after January 19, 2001,

Black lung benefits are awarded to coal miners who are totally disabled by pneumoconiosis caused by inhalation of harmful dust in the course of coal mine employment and to the surviving dependents of coal miners whose death was caused by pneumoconiosis. Coal workers' pneumoconiosis is commonly known as black lung disease.

A formal hearing was held before the undersigned on August 1, 2002 in Morgantown, West Virginia. At that time, all parties were afforded full opportunity to present evidence and argument as provided in the Act and the regulations issued. The record consists of the hearing transcript, Director's Exhibits 1 through 249 (DX 1-249), Claimant's Exhibits 1 and 2 (CX 1-2), and Employer's Exhibits 1 through 3 (EX 1-3). In addition, the "Pre-Trial Statement of Claimant" and "Consolidation Coal Company's Pre-hearing Report and Exhibit List" have been marked and received as Administrative Law Judge Exhibits 1 and 2 (ALJX 1-2), respectively. Pursuant to leave granted at the formal hearing, the record was held open for the submission of simultaneous briefs and reply briefs. The record was closed on September 25, 2002 (TR 15-16).

The findings of fact and conclusions of law which follow are based upon my analysis of the entire record, including all documentary evidence admitted, arguments made, and the testimony presented. Where pertinent, I have made credibility determinations concerning the evidence.

Procedural History

The tortuous procedural history of this case began on or about December 18, 1973, when the Claimant filed his initial application for Federal black lung benefits under the Act (DX 165-1). The claim was repeatedly denied by the Deputy Commissioner's office (n/k/a District Director's office)(DX 165-17; DX 165-18; DX 165-19; DX 165-20). The last denial of the initial claim was issued on March 19, 1980 (DX 165-20). Since the Claimant did not appeal nor take any further action within one year of the March 19, 1980 denial, the above-referred claim is deemed finally denied and administratively closed (DX 249).

Claimant filed the current application for benefits on May 23, 1985 (DX 1). Following

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not to pending cases. Among the provisions which does not apply retroactively is 20 C.F.R. §725.310. *See* 20 C.F.R. §725.2. The Amendments to the Part 718 and 725 regulations were challenged in a lawsuit filed in the United States District Court for the District of Columbia in *National Mining Association v. Chao*, No. 1:00CV03086 (EGS). On February 9, 2001, the District Court issued a Preliminary Injunction Order which enjoined the application of the Amendments except where the adjudicator, after briefing by the parties to the pending claim, determines that the regulations at issue in the instant lawsuit will not affect the outcome of the case. On August 9, 2001, the United States District Court for the District of Columbia issued a decision granting the U.S. Department of Labor's motion for summary judgment in *National Mining Association v. Chao*, dissolved the Preliminary Injunction, and upheld the validity of the amended regulations. On appeal, the D.C. Circuit issued its decision in *National Mining Ass'n, et al v. Dep't of Labor*, _____F.3d_____(D.C. Cir. June 14, 2002), which further addressed the validity and application of the revised regulations. With the exception of a few provisions, the Court affirmed the validity of the revised regulations, as well as its retroactive application. Under the procedural history and facts herein, the Amendments do not affect the outcome of this claim.

numerous procedural delays, including a Decision and Order of Remand (DX 37), an Order of Continuance (DX 38), a Motion for Remand (DX 52), an Order by the Benefits review Board (DX 53), and a pre-hearing telephone conference call (DX 72), a formal hearing was held on February 12, 1991 before Administrative Law Judge Charles P. Rippey (DX 74). Subsequently, Judge Rippey issued a Decision and Order — Denial of Benefits, dated March 22, 1991 (DX 75). On appeal, the Benefits Review Board issued a Decision and Order, dated May 25, 1995, in which Judge Rippey's decision denying benefits was affirmed in part, vacated in part, and remanded for further proceedings (DX 94). Subsequently, the Board issued a Decision and Order on Reconsideration *En Banc*, dated October 22, 1996, in which some of the relief sought by Employer was granted, but its request that the denial be affirmed was rejected (DX 97). Thereafter, Administrative Law Judge Clement J. Kichuk issued a Decision and Order on Remand - Denying Benefits, dated June 20, 1997 (DX 106).

Following Claimant's timely reconsideration request, Judge Kichuk issued a Decision and Order on Claimant's Motion for Reconsideration, dated July 15, 1997, in which Claimant's motion was denied, and the denial of the claim was reaffirmed (DX 108). However, on appeal, the Benefits Review Board issued a Decision and Order, dated July 28, 1998, in which Judge Kichuk's decision denying benefits was affirmed in part, vacated in part, "and remanded to the district director to provide a complete pulmonary examination and for further consideration of the merits of this claim in light of the new evidence." (DX 118). Furthermore, on November 5, 1998, the Board issued an Order on Motion for Reconsideration, denying Employer's reconsideration request (DX 124).

Pursuant to the Board's ruling, the case was returned to the District Director's office for a complete pulmonary evaluation. On December 3, 1999, the District Director issued a Proposed Decision and Order Granting (Claimant's) Request for Modification based upon the finding of complicated pneumoconiosis (DX 159,162). Following Employer's timely request for a formal hearing (DX 161) and the further development of medical evidence, the case was forwarded to the Office of Administrative Law Judges. A formal hearing was held before Administrative Law Judge Gerald M. Tierney on August 10, 2000 (DX 202). Subsequently, Judge Tierney issued a Decision and Order Awarding Benefits, dated April 16, 2001 (DX 214).

On or about May 15, 2001, the Employer filed a timely Notice of Appeal (DX 218). During the pendency of Employer's appeal before the Board, however, the Employer also filed a timely modification request on or about June 28, 2001 (DX 226). On August 23, 2001, the Benefits Review Board issued an Order dismissing Employer's appeal and remanding this case to the District Director for modification proceedings (DX 233). On November 16, 2001, the District Director issued a Proposed Decision and Order Denying (Employer's) request for Modification (DX 243). By letter, dated November 21, 2001, Employer noted that the District Director had failed to consider all of the evidence presented on modification (DX 243). On January 16, 2002, the District Director provided a cursory reference to the additional medical evidence and, again, issued a Proposed Decision and Order Denying (Employer's) Request for Modification (DX 245). Following Employer's timely request for a formal hearing (DX 246), this matter was referred to the Office of Administrative Law Judges for adjudication (DX 247, 249). As stated above, a formal hearing was held on August 1, 2002, and the record was closed on September 25, 2002 (TR 15-16).

Issues

Although the Employer listed almost every conceivable issue as contested on the Form CM-1025 transmittal sheet (DX 247), Employer narrowed the issues in its pre-hearing report and at the formal hearing. The primary contested issues in this matter are as follows:

I. Whether the miner had pneumoconiosis as defined by the Act and the regulations?
II. Whether the miner's pneumoconiosis arose out of his coal mine employment?
III. Whether the miner was totally disabled?
IV. Whether the miner's disability was due to pneumoconiosis?
V. Whether the evidence establishes a change in conditions and/or that a mistake was made in the determination of any fact in the prior award per 20 C.F.R. §725.310.

(ALJX 2; TR 13-14).[3]

Although the summary of the medical evidence, as outlined below, does not delineate between evidence presented in the 1973 claim and evidence submitted in conjunction with the current, 1985 claim, I have, in fact, initially analyzed only the post-final denial medical evidence (*i.e.*, since March 19, 1980).

As summarized below, the preponderance of the evidence presented since the March 19, 1980 final denial (DX 165-20) of the December 18, 1973 claim (DX 165-1) establishes, at least, simple coal worker's pneumoconiosis. Since the Claimant's failure to establish pneumoconiosis was one of the bases upon which the initial claim was finally denied (DX 165-20), a material change in condition has clearly been established under 20 C.F.R. §725.309. *See, Lisa Lee Mines v. Director, OWCP*, 57 F.3d 402 (1995), *aff'd.*, 86 F.3d 1358 (4th Cir. 1996)(en banc), *cert. denied*, 117 S.Ct. 763 (1997)(where the Fourth Circuit followed the one-element standard set forth by the Sixth Circuit in *Sharondale Corp. v. Ross*, 42 F.3d 993 (6th Cir. 1994), in which consideration of all of the post-final denial evidence, favorable and unfavorable, must be made to determine whether the miner has proven at least one of the elements of entitlement previously adjudicated against him to establish a material change).

[3] The transmittal sheet erroneously refers to modification of the prior "denial," when, in fact, the modification request was made by the Employer of Judge Tierney's decision awarding benefits (DX 247, Issue 15). In the absence of a survivor's claim, the issue of death due to pneumoconiosis is not before me for consideration. Thus, the "Causation" issue is limited to the question of whether the miner's disability was due to pneumoconiosis (DX 247, Issue 9). I note, however, that the analysis of the evidence, in particular relating to the presence or absence of *complicated* pneumoconiosis, could be relevant if such a claim were filed. Finally, the "Other Issues" contested by Employer are preserved for appeal (DX 249, Issue 18; TR 13-14).

Findings of Fact and Conclusions of Law

The threshold issue herein is whether the Employer's modification request should be granted. Specifically, whether a change in conditions or mistake in a determination of fact has been established regarding Judge Tierney's Decision and Order-Awarding Benefits, dated April 16, 2001 (DX 214). *See* 20 C.F.R. §725.310.

In summary, Judge Tierney made the following findings: Claimant did not establish *complicated* pneumoconiosis by a preponderance of the chest x-ray evidence;[4] nor did he establish *complicated* pneumoconiosis by a preponderance of the CT scan evidence. Furthermore, of the four physicians who are Board-certified pulmonary specialists who are B-readers, Drs. Bellotte and Fino clearly stated that the Claimant did not have complicated pneumoconiosis. Moreover, Dr. Renn, who initially diagnosed complicated pneumoconiosis by x-ray, subsequently retracted the diagnosis. Nevertheless, Judge Tierney accorded the most weight to the opinion of Dr. Jaworski, who stated that complicated pneumoconiosis is the most appropriate diagnosis in this case, even though he acknowledged that some of the abnormalities are not typical or common in cases involving complicated pneumoconiosis. Based upon Dr. Jaworski's opinion, Judge Tierney found that the irrebuttable presumption contained in §718.304 was applicable. Accordingly, benefits were granted (DX 214).

Medical Evidence

Except as vacated by the Board or superseded herein, the medical evidence which was set forth in prior decisions by various administrative law judges and the Benefits Review Board (DX 75,94,97,106,108,118,214) is incorporated by reference herein. Such evidence is also summarized in Employer's pre-hearing report (ALJX 2). More importantly, the record contains significant additional medical evidence submitted in conjunction with Employer's modification request, which was not addressed in Judge Tierney's Decision and Order-Awarding Benefits, dated April 16, 2001 (DX 214).

The record reveals that the formal hearing before Judge Tierney was held on August 10, 2000 (DX 202). However, due to delays related to the new amendments to the regulations (*See* note 2), Judge Tierney did not issue his decision until April 16, 2001 (DX 214). In the interim, Claimant died on October 10, 2000 (CX 2). However, Judge Tierney apparently was unaware of the miner's death. There is no reference in the aforementioned decision to the miner's death and/or to autopsy evidence (DX 214).

The new medical evidence includes the miner's death certificate (CX 2) and the medical opinions of Drs. Wedemeyer (DX 226,237; CX 1; EX 2, Bush Deposition Exhibit 4), Bush (DX

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[4] Although the administrative law judge found that "Claimant does not establish, by the preponderance of the chest x-ray evidence, the existence of complicated pneumoconiosis at §718.304." (DX 214, p. 5); he also stated: "Based on Dr. Jaworski's identification of at least a category A opacity on Claimant's December 1989 chest x-ray, I find that Claimant's benefits shall commence December 1989 (DX 214, p. 11).

226,244; EX 2), Oesterling (DX 232, 241; EX 3), and Crouch (DX 236).

The miner's death certificate, signed by Dr. Gerald T. Wedemeyer, states that the Mr. Wagner died on October 10, 2000, at age 75 (CX 2). The immediate cause of death was reported as arteriosclerotic coronary artery disease due to coalworkers pneumoconiosis. As previously noted, the question of "death due to pneumoconiosis" is not at issue herein, since there is no survivor's claim under consideration. The listing of "coalworkers pneumoconiosis" on the death certificate, if credited, would tend to support a finding of pneumoconiosis under §718.202(a); however, it neither precludes nor establishes *complicated* pneumoconiosis pursuant to §718.304. Moreover, the death certificate, in and of itself, is not well-documented or well-reasoned. Furthermore, Claimant's counsel stated that the death certificate was submitted for the purpose of showing that the miner had died; not to prove the presence of complicated pneumoconiosis (TR 8). In view of the foregoing, the death certificate is accorded little weight regarding the merits of this claim.

Dr. Gerald T. Wedemeyer, who is Board-certified in Anatomic and Clinical Pathology with additional qualifications in Ctytopathology and Hematology (DX 237, Deposition Exhibit 1), conducted the autopsy of Mr. Wagner (DX 226; DX 237, Deposition Exhibit 2). In a report, dated October 12, 2000, Dr. Wedemeyer stated:

> Preliminary autopsy diagnoses are as follows:
>
> I. Coal workers pneumoconiosis.
>
> II. Status post coronary artery bypass grafts.
>
> A. Evidence of old myocardial infarct.
> B. Left ventricular dilation.
> C. Right Ventricular dilation and hypertrophy.
>
> Final autopsy report will follow.

(DX 237, Deposition Exhibit 2).

The final autopsy report was issued by Dr. Wedemeyer on October 27, 2002 (DX 226; DX 237, Deposition Exhibit 2). The autopsy report notes that the autopsy was limited to the "chest only." It includes Dr. Wedemeyer's description of his Gross Examination of the respiratory and cardiovascular systems, his findings on Microscopic Examination of the lungs and heart, and the miner's Clinical History. Based upon the foregoing, Dr. Wedemeyer set forth the following final anatomic diagnoses:

> I. History of occupational exposure to coal dust (underground miner).
>
> II. Coal workers pneumoconiosis.
>
> A. Severe panlobular and bullous emphysema
> B. Deposition of coal and silica particles
> C. Coal nodules and fibrosis.
> D. Right ventricular hypertrophy suggesting pulmonary hypertension.

III. Coronary atherosclerosis.
    A. Myocardial infarcts, old.
    B. Status post coronary artery bypass graft with atherosclerosis of the graft.
    C. Status post pacemaker insertion.

(DX 226; DX 237, Deposition Exhibit 2).

In testimony at deposition held on August 21, 2001 (DX 237), Dr. Wedemeyer noted that he had reported black nodules 2 to 3 cm in diameter on his autopsy report (DX 237, p. 11; *See also,* DX 237, Deposition Exhibit 2, p. 2, Gross examination-Respiratory). Dr. Wedemeyer testified that he "sampled quite widely throughout both lungs and made slides from those samples." Although he did not initially take pictures of the lungs, he retained a large portion of the lungs and heart in his archives. While failing to record the number of slides, he recalled there were 24 slides. The 24 slides were made available to reviewing pathologists, such as Drs. Bush and Oesterling. As of the date of Dr. Wedemeyer's deposition, the other material which was located in the archives were not available to the other pathologists (DX 237, pp. 11-12).

On gross examination of the heart, Dr. Wedemeyer found that it was large, and that both the left ventricle and right ventricle were "very dilated." He also noted severe coronary artery disease, coronary artery bypass grafts, and scars indicating previous myocardial infarcts. Dr. Wedemeyer stated that the dilation of the left ventricle generally indicates heart failure, while the "dilation of the right side of the heart indicates that there was probably pulmonary hypertension, meaning that there was some impedence (sic) to blood flow in the lung and the right side of the heart had enlarged and dilated to compensate for that." Based upon the foregoing, Dr. Wedemeyer opined that cor pulmonale was present. Furthermore, he stated that the most probable explanation in this case was that the cor pulmonale was caused by the presence of coal dust disease (DX 237, pp. 12-13).

Dr. Wedemeyer testified that approximately one week prior to his deposition, he retrieved the miner's lungs from the archives. He reexamined the lungs and the heart, and took photographs of them. Dr. Wedemeyer discussed various photographs in his deposition testimony. Furthermore, the photographs were included as a deposition exhibit (DX 237, pp. 14-18; DX 237, Deposition Exhibit 4). Citing a scale in Photograph 1, Dr. Wedemeyer described various nodules on the photographs which revealed several nodules ranging between 1 ½ cm and 3 cm. Accordingly, Dr. Wedemeyer opined that this is evidence of progressive massive fibrosis (DX 237, pp. 17-18). In summary, Dr. Wedemeyer stated that he would expect nodules 2 to 3 cm in diameter, as found on autopsy, would appear greater than 1 cm on x-ray. The foregoing is sufficient to warrant a diagnosis of progressive massive fibrosis. Therefore, based upon his gross examination and the review of the slides, Dr. Wedemeyer concluded that Mr. Wagner suffered from progressive massive fibrosis (DX 237, pp. 21-23).

On cross-examination, Dr. Wedemeyer acknowledged that, in his autopsy report, he had diagnosed coal worker's pneumoconiosis, but had not used the terms progressive massive fibrosis or complicated pneumoconiosis (DX 237, p. 24). In addition, Dr. Wedemeyer acknowledged that he did not know if the Claimant had been a cigarette smoker (DX 237, p. 25); nor did he know when the Claimant last worked in the coal mines (DX 237, p. 38); nor did he know whether the disease had progressed after Claimant left the coal mines (DX 237, p. 38); nor did he know if

Claimant had any clinical impairment during his lifetime (DX 237, p. 39); nor did he know whether Claimant had any history of recurrent pneumonia throughout his lifetime (DX 237, p. 40). Nevertheless, Dr. Wedemeyer stated that, in this case, he would not defer to physicians who have greater expertise, because he was the one who performed the autopsy (DX 237, p. 36); and, that he is in the best position to making a finding regarding the cause of Claimant's death and whether he had complicated pneumoconiosis or progressive massive fibrosis (DX 237, p. 39).

Dr. Wedemeyer also issued a supplemental letter, dated June 15, 2002 (CX 1). The full text of the letter is as follows:

> I have read the letters of Drs. Crouch and Bush, but it is still my opinion that Mr. Wagner had the lesions characteristic of progressive massive fibrosis, namely coal nodules from 2-3 cm. The gross examination accounts for about 60% of the time I spend in completing an autopsy; thus, I am in a unique position to judge the condition of Mr. Wagner's lungs. I am the only pathologist who saw them *in situ* or who handled and palpated them both before and after inflation with formalin. I am also the only pathologist who examined all of the lung tissue. Other pathologists have seen only microscopic slides or tissue fragments remaining after extensive dissection. I saw, felt and measured coal nodules ranging from 2 to 3 cm. The microscopic preparations confirm that the 2 to 3 cm lesions described are coal nodules.

(CX 1).

The record also contains Dr. Wedemeyer's letter, dated June 20, 2002 (and related handwritten notes by Dr. Bush), which is virtually identical to the June 15, 2002 correspondence outlined above, except that Dr. Wedemeyer referred to "letters from Drs. Crouch, Bush and Oesterling," not simply to those of Drs. Crouch and Bush (EX 2, Bush Deposition Exhibit 4; *Compare* CX 1).

Dr. Stephen T. Bush, who is Board-certified in Anatomic and Clinical Pathology and in Medical Microbiology (EX 2, pp. 8), issued a report, dated January 24, 2001, in which he reviewed and analyzed the available medical evidence, as well as the histologic slides (DX 226). Based upon the foregoing. Dr. Bush responded to various questions posed by Employer's counsel, as follows:

> 1. Mr. Wagner had evidence of a mild degree of simple coalworkers' pneumoconiosis evident by the deposition of dust pigment with an apparent fibrous reaction producing localized subpleural nodules measuring up to 0.7 cm. Fibrous scarring in a number of sections apparently represent the apical lesions which contain a relatively small amount of black dust pigment consistent with coal dust and a prominent amount of iron pigment, probably residue from tissue destruction and chronic congestive heart failure. The tissue destruction is attributable to past inflammatory reaction from old infectious process. Subpleural emphysematous change is associated with the area of scarring. Elastic degeneration is moderately extensive in the fibrous tissue which also reflects changes due to a past infectious process and repair. One (1) slide contains a large area of glanular debris which is

not pigmented surrounded by foreign body giant cells.

The sections of lung other than those apparently representing apex show severe congestion and edema within air spaces consistent with acute severe congestive heart failure. An occasional focus of fibrosis without any pigment whatever can be found.

I disagree with the diagnosis of progressive massive fibrosis (PMF) because of the absence of clinical findings of significant respiratory impairment, the absence of consistent radiographic findings of significant occupational pneumoconiosis and the absence of pathologic findings consistent with progressive massive fibrosis as described in the July 1979 Archives of Pathology, page 379. The description of progressive massive fibrosis includes reference to the published description by Gough (1940) "an appearance like lumps of coal." No such description appears in the autopsy protocol. The authors indicate that progressive massive fibrosis occurs in a "background of simple coalworkers' pneumoconiosis." The background in these lungs is one of minimal change, with areas outside the apex showing only rare coalworker nodules. The reference described the PMF lesion as "solid, pigmented, rubbery to hard" again not described in this autopsy protocol. Most lesions of PMF which I have seen conform to the description having "regions of cavitation containing only fluid" which was not described in the autopsy protocol. PMF lesions "frequently cross and obliterate lobar and lesser fissures" but this finding is not evident in the report microscopically.

Finally, the description includes "the remainder of the lung...is almost invariably heavily pigmented." Heavy pigmentation is clearly not present in any of the microscopic slides even those from the apical lesions. For these reasons the diagnosis of progressive massive fibrosis and the implications related thereto regarding the severity of disease is not appropriate.

2. Chronic dust disease of the lungs did not cause respiratory impairment or disability during the miner's lifetime. This is based on the absence of consistent abnormalities in pulmonary function studies showing impairment and the absence of severe diffuse bilateral disease on histologic examination of the slides, supported by the gross description of the lungs showing localized disease in the apical regions.

3. Death resulted from acute heart failure due to atherosclerotic coronary artery disease. This conclusion is based on the available medical evidence of known severe coronary artery disease producing previous extensive myocardial infarctions evident in the histologic slides as scarring and thinning of the left ventricular wall. The lungs show severe congestion and acute pulmonary edema consistent with left ventricular failure. The microscopic appearance of myocardium of the left ventricle shows fragmentation of fibers and prominent, dark nuclei indicating acute stress to the left ventricular muscle. Coronary artery sections show severe atherosclerotic disease with marked decreased (sic) in lumen size and at least two areas of hemorrhage within the atherosclerotic plaques. This is a typical finding in

acute coronary insufficiency leading to fatal myocardial disease.

4. Death was not caused, contribute to, or hastened by any chronic dust disease due to coal mine employment. The lung disease related to dust deposition is very limited and would not be expected to produce significant effects in pulmonary function or contribute to death from the effects of severe coronary artery disease. Death would have occurred at the same time and in the same manner if Mr. Wagner had never been exposed to the pulmonary hazards of coal mine employment.

I note that although Dr. Jaworski (7/16/99) and Dr. Renn (9/29/99) make the diagnosis of progressive massive fibrosis, they are clear in their conclusion that significant pulmonary impairment is not present.[5] I conclude that coalworkers' pneumoconiosis is limited in overall extent, although locally destructive in the apices. I also note that the autopsy pathologist describes "refractive material" suggesting silica, but my polarized light examination shows a large number of long crystals randomly over the tissue and beyond the histologic slides. These particles are also present in the sections of the heart indicating contaminating material from processing rather than inhaled mineral particles. The amount of silica particles are weakly birefringent and small. I note a mild to moderate degree of centrilobular emphysema which is more severe in the sections from the apical areas and is most reasonably attributed to the affects of the long history of cigarette smoking. In addition, large airways showed a marked increase in the number of mucous glands consistent with the affects of chronic bronchitis from cigarette smoking.

(DX 226).

In a supplemental report, dated November 27, 2001 (DX 244), Dr. Bush reviewed the deposition transcript of Dr. Wedemeyer, dated August 21, 2001, and he examined the formalin-fixed tissue from Mr. Wagner's autopsy. In summary, Dr. Bush disagreed with Dr. Wedemeyer's finding of nodules measuring 2 to 3 cm, stating that his own examination of the lungs establishes fibrotic nodules which measure no more than 0.8 cm. Furthermore, Dr. Bush challenged Dr. Wedemeyer's diagnosis of cor pulmonale noting that "the absence of right ventricular hypertrophy in Mr. Wagner strongly suggests that the lung disease was not severe enough to cause right ventricular disease." In addition, Dr. Bush stated that Dr. Wedemeyer artificially demarcated dark areas in photograph #2, which, in comparison, to the ruler in the photograph, measure closer to 1 cm than 2 cm. Similarly, Dr. Bush questioned Dr. Wedemeyer's finding of black pleura in photograph #4, noting that it actually showed rather insignificant pigmentation. Moreover, Dr. Bush noted that Dr. Wedemeyer emphasized the size of lesions and sometimes ignored the fact that progressive massive fibrosis implies a severe degree of lung disease from coal worker's pneumoconiosis. Yet, in the case of Mr. Wagner, the degree of disease from coal dust exposure is mild. Accordingly, Dr. Bush concluded:

[5] Dr. Renn subsequently retracted his diagnosis of complicated pneumoconiosis (DX 170; Renn Deposition).

> My review of the tissue and photographs with the deposition transcript add significantly to my confidence that the opinions expressed in my letter of 01/24/01 are correct with a high degree of reasonable medical certainty.

(DX 244).

Dr. Bush also testified at deposition on July 24, 2002 (EX 2). His testimony indicates partial agreement with Dr. Wedemeyer's diagnosis of cor pulmonale. However, Dr. Bush testified that the autopsy evidence indicated acute, not chronic, cor pulmonale, which he related to biventricular disease (EX 2, pp. 35-37,80-82). Furthermore, Dr. Bush clearly reiterated his finding of only simple coal worker's pneumoconiosis. Dr. Bush stated that there was autopsy evidence of a localized nodular disease, with the largest abnormality being 0.7 or up to 0.8 cm (EX 2, pp. 37-38, 60). Dr. Bush acknowledged that one may not be able to get an entire large nodule on a slide. However, Dr. Bush explained: "And that is why if there is a large nodule, you don't necessarily see the end of the nodule, but the whole slide or the whole piece of tissue would be dust, scar --- and that's the way a TMF (sic) lesion would look on a histologic slide. The entire thing would be scarred. And that's typically what you would find. You understand that the whole thing isn't there. It's bigger than what's on the slide because it goes beyond the edges." (EX 2, p. 80). Moreover, Dr. Bush also sought to explain the possible basis for Dr. Wedemeyer's findings of nodules 2 or 3 cm as contrasted to his own finding of up to 0.8 cm, as follows: "The only conclusion I can make is that perhaps Doctor Wedemeyer was looking at several nodules that were, as I said, up to 0.8 centimeters, dust pigment and kind of in his evaluation, considering several nodules as to be one nodule and achieved a measurement of that size." (EX 2, pp. 60-61). Furthermore, Dr. Bush rejected Dr. Wedemeyer's suggestion that, as the prosector, he (*i.e*, Dr. Wedemeyer) had a distinct advantage, because he had a chance to look at the gross tissue taken from the autopsy. To the contrary, Dr. Bush testified, in pertinent part:

> I think we are pretty near equal in our ability to arrive at a logical and reasonable and definite conclusion. It's true that the tissue that I had was not the sum total of all of the lung tissue. But if we accept the premise, the reasonable premise that the preserved tissue would be the diseased tissue in the lungs, then, we are quite equal in arriving at a conclusion.

(EX 2, p. 56). Dr. Bush explained further that it is reasonable to assume that the preserved tissue is most representative of the diseased state of the lung, because "it would be illogical to discard the diseased lung and save the not diseased lung." (EX 2, p. 56).

In summary, Dr. Bush testified that his autopsy finding of only a mild degree of coal worker's pneumoconiosis is consistent with negative chest x-ray findings and the results of pulmonary function testing, which does not indicate life time disability (EX 2, p. 38,64); and, that Claimant's simple pneumoconiosis, which arose out of coal mine employment, did not play any role in causing a life time disability and/or in causing or hastening Mr. Wagner's death (EX 2, pp. 63-64).

Dr. Everett F. Oesterling, who is Board-certified in Anatomical and Clinical Pathology, as well as Nuclear Medicine (EX 3, pp. 3-4), issued a report, dated July 2, 2001 (DX 232). Dr. Oesterling stated that he reviewed various medical data; in particular, 23 histologic slides. In

addition, he utilized photomicrographs to illustrate his findings. Based upon his analysis of the evidence, Dr. Oesterling concluded:

> In summary, it can be stated with reasonable degree of medical certainty that this gentleman had moderate micronodular coalworkers' pneumoconiosis with some areas of confluence of the micronodules, the latter being significantly complicated by other underlying pulmonary disease processes. The level of coalworkers' disease present appears insufficient to have altered pulmonary function, thus it should not have produced pulmonary disability and indeed his clinical records reflect that this gentleman had no significant physiologic alterations due to his coalworkers' disease. Therefore, coalworkers' disease could not have been a factor in precipitating or hastening his death.

(DX 232).

In a supplemental report, dated October 19, 2001 (DX 241), Dr. Oesterling reviewed additional materials, including the reports and deposition of Dr. Wedemeyer. Furthermore, Dr. Oesterling analyzed various autopsy-related photographs. Dr. Oesterling found "biventricular enlargement and dilation," which he stated "is not an example of cor pulmonale." Furthermore, Dr. Oesterling described various abnormal findings, none of which qualified for a diagnosis of progressive massive fibrosis. In summary, Dr. Oesterling stated:

> In concluding I would again state with reasonable medical certainty that his gentleman's disease process is that of a moderate micronodular coalworkers' pneumoconiosis, there being no evidence of progressive massive fibrosis in tissue samples.

(DX 241).

In testimony at deposition held on July 18, 2002 (EX 3), Dr. Oesterling reiterated that, in his opinion, the autopsy findings were insufficient to establish complicated coal workers' pneumoconiosis or progressive massive fibrosis. Dr. Oesterling quantified the degree of pneumoconiosis as follows:

> To me it was a micro nodular disease process, nowhere near a massive progressive fibrosis....
>
> Actually the largest lesion that I saw was less than 7 millimeters. And 7 millimeters is usually the cut-off between micro nodular and macro nodular disease. I did not see evidence of macro nodular disease.

(EX 3, p. 34). In addition, Dr. Oesterling stated that, in his experience, a person who has progressive massive fibrosis or complicate coal worker's pneumoconiosis typically suffers significant alterations of function and, in severe cases, it contributes to death. However, Dr. Oesterling acknowledged that one area of progressive massive fibrosis may not significantly impair pulmonary function (EX 3, pp. 34-35). Dr. Oesterling also conceded that the tissue sections seen by microscope are usually limited to approximately 2 cm. By 2 cm. Thus, a nodule

3 cm in size would not fit on the slide (EX 3, p. 38). Nevertheless, Dr. Oesterling rejected the suggestion that the pathologist who made the gross evaluation is in a much better position than a reviewing pathologist, stating, in pertinent part:

> As I've said basically the finite way of determining the etiology of a scar is with a microscope and I saw none of the tissue of any significance that was scarred that was of coal mine origin beyond micronodules.

(EX 3, pp. 38-39). Moreover, Dr. Oesterling further explained:

> ...But we are still back to the first topic, gross examination versus microscopic examination. Gross tissue is not a way that we can make a diagnosis of progressive massive fibrosis. We have to see corresponding histologic changes to make that diagnosis.

(EX 3, pp. 46-47). Furthermore, Dr. Oesterling explained that the abnormalities which Dr. Wedemeyer classified as complicated pneumoconiosis due to dust disease were actually hemosiderosis related to fibrotic lung disease (EX 3, pp. 46-50).

Dr. Erika C. Crouch, a Professor of Pathology and Immunology at Washington University, issued a pulmonary pathology consultation report, dated August 15, 2001 (DX 13). Dr. Crouch listed various medical data which she had reviewed. Furthermore, Dr. Crouch set forth her own microscopic findings on examination of the autopsy slides. Based upon the foregoing, Dr. Crouch stated:

> Diagnosis:
>
> | | | |
> |---|---|---|
> | Lungs, autopsy | -: | emphysema, predominantly panacinar and distal acinar |
> | | -: | simple coal workers' pneumoconiosis, moderate (see comment) |
>
> Comment:
>
> The histologic slides show coal dust macules, micronodules, and some nodular lesions consistent with simple coal workers' pneumoconiosis. A few sections show changes somewhat suggestive of larger pneumoconiosis lesions; however, the histologic features are not characteristic of massive fibrosis or conglomerate silicosis and the surrounding lung does not show changes of severe, simple pneumoconiosis. The pathologic assessment is consistent with the available clinical and radiographic data which do not suggest massive fibrosis or complicated pneumoconiosis. This patient's major clinical problem related to atherosclerotic cardiovascular disease with old and recent myocardial ischemic episodes. Thus, occupational coal dust exposure could not have caused any clinically significant degree of functional impairment and could not have caused, contributed to or otherwise hastened this patient's death secondary to complications of atherosclerotic cardiovascular disease. Although there is emphysema, and this obstructive lung disease may have placed an additional burden on this heart, the pattern of emphysema and the absence of any

> concordance between the severity of the emphysema and the observed pneumoconiosis indicates that the lung destruction is secondary to cigarette smoking.

(DX 236).

DISCUSSION AND ANALYSIS

Modification Under 20 C.F.R. §725.310

Since this case involves a modification request by the Employer regarding the miner's claim, the threshold issue is whether the Employer has established a change in condition or mistake in a determination of fact, as provided in §725.310. In evaluating a modification request, I cannot simply conduct a substantial evidence review, but rather, I must make a *de novo* consideration of the evidence. Accordingly, I must perform an independent assessment of the newly submitted evidence, in conjunction with the previously submitted evidence, to determine if the weight of the evidence is sufficient to establish grounds for modification. As discussed herein, all of the evidence has been considered and weighed.

Summary of Medical Evidence

The case file includes numerous interpretations of various chest x-rays covering the period from June 28, 1973 through September 20, 1999 (ALJX 2). The early x-ray evidence from June 28, 1973 through June 4, 1986 is overwhelmingly negative for pneumoconiosis. However, a clear majority of the x-ray interpretations of films dated December 21, 1989 through September 20, 1999 is positive for, at least, simple pneumoconiosis. Although a few of the above-referred positive readings reveal large opacities consistent with complicated pneumoconiosis, the clear preponderance of such x-ray evidence, including the interpretations by dual-qualified B-readers and Board-certified radiologists, is negative for *complicated* pneumoconiosis (ALJX 2). Therefore, I find that, taken as a whole, the x-ray evidence supports a finding of *simple* pneumoconiosis.

The record also contains numerous interpretations of various CT scans, dated September 23, 1999 through April 20, 2000 (ALJX 2). Although Dr. Brandon, a dual-qualified B-reader and Board-certified radiologist, found complicate pneumoconiosis on two Ct scans, his findings are outweighed by the multiple interpretations of Drs. Wheeler, Scoot, and Kim, who are similarly well-qualified. Accordingly, I find that complicated pneumoconiosis has not been established by a preponderance of the CT scan evidence.

The case file contains numerous pulmonary function studies which were performed between January 5, 1974 and September 20, 1999 (ALJX 2). The overwhelming preponderance of the pulmonary function study evidence is nonqualifying under the applicable regulatory criteria set forth in Part 718, Appendix B. Moreover most of the studies were interpreted as showing little, if any, respiratory or pulmonary impairment (ALJX 2).

The record includes arterial blood gas studies which were administered between June 11, 1979 and July 16, 1999. The results are clearly nonqualifying under the standards set forth in Part

718, Appendix C. (ALJX 2).

The pre-modification medical evidence included numerous physicians' opinions (ALJX 2). None of the credible, early medical opinion evidence established a totally disabling respiratory or pulmonary impairment of the presence of complicated pneumoconiosis. To the contrary, such evidence established Claimant's history of heart disease, and that Claimant could perform his last usual coal mine job from a respiratory or pulmonary standpoint. However, as stated above, Judge Tierney issued a Decision and Order-Awarding Benefits, dated April 16, 2001, in which he granted benefits based upon Dr. Jaworski's finding of complicated pneumoconiosis under §718.304.

In making this determination, Judge Tierney stated, in pertinent part:

> I find the opinion of Dr. Jaworski the most credible. At first glance, Dr. Jaworski's diagnosis "favoring" complicated pneumoconiosis and not excluding old tuberculosis and fungal disease appears equivocal. However, the board-certified pulmonary specialists and B-readers acknowledged that *absent a biopsy a definitive diagnosis cannot be made in this case.* Dr. Wheeler, the radiological expert, discussed below, Dr. Bellotte, and Dr. Fino carry a more definitive tone in their opinions. Dr. Renn initially diagnosed complicated pneumoconiosis and then retracted it putting it very far down on his list of differential diagnosis (sic), if at all. I do not find the fact that Dr. Jaworski took a more cautious approach in his word choice to distract from his opinion in this case where a definitive diagnosis cannot be made. Dr. Jaworski's testimony that he considered complicated pneumoconiosis the most appropriate diagnosis in this case. Dr. Jaworski testified that "yes," with a degree of medical certainty, he would say that Claimant suffers from complicated pneumoconiosis. The opinions of the equally-qualified fellow physicians, board-certified pulmonary specialists B-readers, Drs. Fino, Renn, and Bellotte, set forth their reasons for not finding complicated pneumoconiosis the appropriate diagnosis in this case. Dr. Jaworski had the opportunity to examine Claimant on more than one occasion. He had the opportunity to do additional testing. Dr. Jaworski pointed out that, unlike a reviewing physician, he had the advantage of having Claimant present and available to ask additional questions. He noted after examining and talking to Claimant he had a better feel of Claimant's past history of exposures and symptoms. Relying on the opinion of Dr. Jaworski, I find that Claimant has established by the preponderance of the physician opinion evidence, the existence of complicated pneumoconiosis.

(DX 214, p. 9) (Emphasis added).

Therefore, even though the preponderance of the x-ray and CT scan evidence did *not* establish complicated pneumoconiosis, Judge Tierney concluded, based upon Dr. Jaworski's opinion, that the §718.304 irrebuttable presumption is invoked. (DX 214, p. 10).

Having considered the new medical evidence presented, in conjunction with the prior evidence, I find that the Employer has established grounds for modification under §725.310. Moreover, with the benefit of the new evidence and hindsight, I find that the finding of

complicated pneumoconiosis in the prior decision is no longer supportable.

Based upon my independent analysis, I agree with Judge Tierney's findings that Claimant has failed to establish complicated pneumoconiosis by a preponderance of the x-ray evidence and/or CT scan interpretations. However, in view of the additional autopsy evidence, I find that Claimant has also failed to establish complicated pneumoconiosis by a preponderance of the physician opinion evidence.

It is well settled that autopsy evidence is the most reliable evidence of the existence of pneumoconiosis. *Terlip v. Director, OWCP*, 8 BLR 1-363 (1985). Similarly, it is most reliable in assessing the extent of the disease. As outlined above, the record contains the opinions of four pathologists, namely, Drs. Wedemeyer, Bush, Oesterling, and Crouch. Of the foregoing, only Dr. Wedemeyer diagnosed complicated pneumoconiosis. The Board has held that greater weight may be accorded to the opinion of the pathologist who performed the autopsy over one who simply reviews the autopsy slides. *Similia v. Bethelhem Mines Corp.*, 7 BLR 1-535 (1984); *See also, Fetterman v. Director, OWCP,* 7 BLR 1-688, 1-691 (1985). However, the Fourth Circuit under whose jurisdiction this case arises (DX 2,3,4) has held that it is error to credit the prosector's opinion over those of reviewing pathologists solely on the basis that the prosector examined the miner's whole body at the time of death. *Bill Branch Coal Co. v. Sparks*, 213 F.3d 186 (4th Cir. 2000). In so holding, the Court cited the Seventh Circuit's decision in *Freeman United Coal Mining Co. v. Stone*, 957 F. 2d 360, 362-63 (7th Cir. 1992) ("[n]othing in the record suggests that access to the whole body enhances the accuracy of diagnoses based on autopsy evidence;" it was error to credit the prosector's report over the reports of reviewing physicians solely because the prosector had access to the whole body)."

In the present case, Dr. Wedemeyer cites his gross examination on autopsy and his ability to see the lungs *in situ* as placing him in a "unique position to judge Mr. Wagner's lungs." In addition, Drs. Bush and Oesterling acknowledged that if the nodules were, in fact, 2 to 3 cm in size, they would extend beyond the autopsy slides. However, Drs. Bush and Oesterling also testified credibly that they were in substantially the same position as Dr. Wedemeyer in assessing whether or not Claimant had complicated pneumoconiosis. Moreover, the record establishes that Drs. Bush, Oesterling, and Crouch reviewed the Claimant's medical and occupational histories and had a more complete clinical picture than Dr. Wedemeyer. *See, Stark v. Director, OWCP*, 9 BLR 1-36 (1986). Furthermore, I find the opinions of Drs. Bush, Oesterling, and Crouch to be more consistent with the preponderance of the x-ray and CT scan evidence, which is negative for complicated pneumoconiosis; the preponderance of the nonqualifying pulmonary function studies and arterial blood gas tests; and, the credible opinions of the majority of the Board-certified pulmonary specialists.[6]

[6] With the benefit of the autopsy evidence, I find that the reliance in the April 18, 2001 decision upon Dr. Jaworski's opinion over the contrary findings of Drs. Bellotte and Fino, and, the revised opinion of Dr. Renn, was misplaced.

In summary, I have considered all of the relevant medical evidence and weighed them together to determine if Claimant has established complicated pneumoconiosis by a preponderance of the overall evidence. Taken as a whole, I find that the preponderance of the x-ray, CT scan, autopsy, and physicians' opinions evidence are negative for complicated pneumoconiosis. Having weighed together the evidence under §718.304(a)-(c) prior to invocation, I find that the Claimant has not invoked the irrebuttable presumption of total disability due to pneumoconiosis, as provided in §718.304. Based upon the foregoing, the Employer has established grounds for modification of the miner's claim pursuant to §725.310.

Total Disability

Where, as here, complicated pneumoconiosis is not established, total disability may still be established by pulmonary function tests, by arterial blood gas tests, by evidence of cor pulmonale with right sided congestive heat failure, or by physicians' reasoned medical opinions, based upon medically acceptable clinical and laboratory diagnostic techniques, that a miner's respiratory or pulmonary condition prevents or prevented the miner from engaging in his usual coal mine work or comparable employment. *See* amended 20 C.F.R. §718.204(b)(2)(i)-(iv).

As outlined above, neither the pulmonary function studies nor arterial blood gas tests are qualifying under the regulatory standards set forth in Part 718, Appendices B and C. Therefore, Claimant has failed to establish total disability pursuant to §718.204(b)(2)(i) and (ii).

As discussed above, the record contains evidence of possible cor pulmonale on autopsy. However, the preponderance of such evidence fails to establish that it is associated with right-sided congestive heart failure. Accordingly, Claimant has also not established total disability pursuant to §718.204(b)(2)(iii).

Finally, I find that the Claimant has failed to establish the presence of total (respiratory or pulmonary) disability on the basis of the medical opinion evidence. To the contrary, the overwhelming preponderance of the medical opinion evidence, including the opinions of well-credentialed Board-certified pulmonary specialists, such as Drs. Renn, Fino, and Bellotte concluded that the Claimant was not totally disabled from a respiratory or pulmonary standpoint. The foregoing opinions are credible and most consistent with the objective clinical test results. Therefore, I find that the Claimant has not established total disability under §718.204(b)(2)(iv), or by any other means.

Assuming *arguendo*, that I had found that the medical evidence warranted a finding of cor pulmonale with right-sided congestive heart failure under §718.204(b)(iii), I would still be required to weigh all the contrary and probative evidence together to determine if Claimant had established total disability under Section 718.204(b) overall. *See Fields v. Island Creek Coal Co.*, 10 BLR 1-19 (1987); *Shedlock v. Bethlehem Mines Corp.*, 9 BLR 1-195 (1986). In such case, I would find that the overwhelmingly nonqualifying pulmonary function studies and arterial blood gas studies, together with the clear preponderance of the medical opinion evidence, was more probative in assessing the true extent of Claimant's respiratory or pulmonary condition. Based upon the foregoing, I would find that the Claimant retained the respiratory or pulmonary capacity to perform his last usual coal mine job. Therefore, I would still find that the Claimant had not established total disability under §718.204(b).

Total Disability Due to Pneumoconiosis

Under the provisions of §718.204(c)(1), "a miner shall be considered totally disabled due to pneumoconiosis if pneumoconiosis, as defined in §718.201, is a substantially contributing cause of the miner's totally disabling respiratory or pulmonary impairment" (*i.e.*, pneumoconiosis had a material adverse effect on the miner's respiratory or pulmonary condition; or, it materially worsened a totally disabling respiratory or pulmonary condition which was caused by a disease or exposure unrelated to coal mine employment). Furthermore, the cause or causes of the Claimant's total disability shall be established by means of a documented and reasoned physician's opinion. *See* amended 20 C.F.R. §718.204(c)(2). Since the Claimant has failed to establish the presence of a totally disabling respiratory or pulmonary impairment, he clearly cannot establish total disability due to pneumoconiosis.

Conclusion

Although the evidence establishes that Claimant had simple pneumoconiosis which arose from his coal mine employment, it does not establish *complicated* pneumoconiosis. Thus, Claimant is not entitled to the irrebuttable presumption of total disability due to pneumoconiosis, as set forth in §718.304. Furthermore, the evidence does not otherwise establish that Claimant suffered from a totally disabling respiratory or pulmonary impairment and/or that he was totally disabled due to pneumoconiosis. In view of the foregoing, the Employer has established grounds for modification under §725.310. Therefore, the Claimant is not entitled to benefits under the Act.

Attorney's Fee

The award of an attorney's fee is permitted only in cases in which Claimant is found to be entitled to benefits. Since benefits are not awarded in this case, the Act prohibits the charging of any fee to Claimant for representation services rendered to Claimant in pursuit of this claim.

ORDER

The claim of Herman Wagner for black lung benefits under the Act is hereby **DENIED.**

Robert J. Lesnick

ROBERT J. LESNICK
Administrative Law Judge

RJL/MP/dmr

NOTICE OF APPEAL RIGHTS: Pursuant to 20 C.F.R. 725.481, any party dissatisfied with this Order may appeal to the Benefits Review Board within 30 days from the date of this Decision and Order, by filing a notice of appeal with the ***Benefits Review Board at P.O. Box 37601, Washington, D.C. 20013-7601.*** A copy of a notice of appeal must also be served on Donald S. Shire, Esquire, Associate Solicitor for Black Lung Benefits, Frances Perkins Building, Room N-2117, 200 Constitution Avenue, N.W., Washington, D.C. 20210.